DD. Vaginal Delivery

(1)	[Reserved for future use]		
(2)	Without Complicating Diagnosis or Operating Room Procedures	373	
(3)	With Operating Room Procedure	374-375	
(4)	With Complicating Diagnosis	372	

EE. [Reserved for future use]

FF. Depressive Neurosis

(1)	(Age 0-17)	426	
(2)	(Age > 17)	426	

GG. Psychosis

(1)	(Age 0-17)	430	
(2)	(Age > 17)	430	

HH. Childhood Mental Disorders 431

II. Operating Room Procedure Unrelated to Principal Diagnosis

(1)	[Reserved for future use]		
(2)	Nonextensive	476, 477	
(3)	Extensive (Age 0-17)	468	
(4)	Extensive (Age > 17)	468	

JJ. [Reserved for future use]

KK. Extreme Immaturity

(1)	(Weight < 1500 Grams)	386	76501 to 76505
		387	76500
(2)	[Reserved for future use]		
(3)	[Reserved for future use]		
(4)	[Reserved for future use]		
(5)	Neonate Respiratory Distress Syndrome	386	Codes for DRG 386 except 76501 to 76505

LL. Prematurity with Major Problems

(1)	(Weight < 1250 Grams)	387	76511 to 76514
(2)	(Weight 1250 to 1749 Grams)	387	76506, 76510 76515, 76516

(3) (Weight > 1749 Grams)	387	Codes for DRG 387 except 76500, 76506, 76510 to 76516
MM. Prematurity without Major Problems	388	
NN. Full Term Neonates		
(1) With Major Problems	389	
(2) With Other Problems	390	
OO. Multiple Significant Trauma	484-487	
PP. [Reserved for future use]		
QQ. Normal Newborns	391	
RR.-TT. [Reserved for future use]		
UU. Organ Transplants		
(1) Heart, Liver, Bone Marrow, Lung	103, 480, 481, 495	
(2) [Reserved for future use]		
VV. [Reserved for future use]		
WW. Human Immunodeficiency Virus	488-490	

C. Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part. The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part, regardless of program eligibility:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS
A. Nervous System Diseases and Disorders	001-035	except codes in XX

B.-G. [Reserved for future use]

H. Diseases and Disorders of the Musculo-Skeletal System & Connective Tissues	209-213, 216- 220, 223- 256, 471, 491, 496-503	except codes in XX

I.- QQ. [Reserved for future use]

RR. Mental Diseases and Disorders/ Substance Use and Substance Induced Organic Mental Disorders	424-432, 434, 435	except codes in XX
SS. Multiple Significant Trauma/ Unrelated Operating Room Procedures	468, 476, 477, 484-487	except codes in XX
TT. Other Conditions Requiring Rehabilitation Services	036-108, 110-208, 257-423, 439-455, 457-467, 472, 473, 475, 478-483, 488-490, 492, 495	except codes in XX

UU. [Reserved for future use]

VV. Quadraplegia and Quadriparesis Secondary to Spinal Cord Injury	all DRGs with ICD-9 diagnoses codes: 344.01, 344.02-344.04, 344.09 in combination with 907.2	

D. Diagnostic categories for neonatal transfers. The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units, regardless of program eligibility:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS
A. - JJ. [Reserved for future use]		
KK. Extreme Immaturity		
(1) (Weight < 750 Grams)	386	76501, 76502
(2) (Weight 750 to 999 Grams)	386	76503
(3) (Weight 1000 to 1499 Grams)	386	76504, 76505
	387	76500
(4)	[Reserved for future use]	
(5) Neonate Respiratory Distress Syndrome	386	Codes for DRG 386 except 76501 to 76505
LL. Prematurity with Major Problems		
(1) (Weight < 1250 Grams)	387	76511, 76512, 76513, 76514
(2) (Weight 1250 to 1749 Grams)	387	76506, 76510, 76515, 76516
(3) (Weight 1250 to 1749 Grams)	387	Codes for DRG 387 except 76500, 76506, 76510 to 76516
MM. Prematurity without Major Problems (Weight > 1749 Grams)	388	
NN. Full Term Neonates		
(1) With Major Problems (Age 0)	389	
(2)	With Other Problems	390
OO.-WW. [Reserved for future use]		

E. Additional DRG requirements.

1. Version 15 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

2. The discharge status will be changed to "discharge to home" for DRG 385, 433, and 456.

3. A diagnosis with the prefix "v57" will be excluded when grouping under all diagnostic categories under item C.

4. For neonates transferred to a neonatal intensive care unit with a DRG assignment of DRG 482 or DRG 483, the ICD-9-CM procedure codes 30.3, 30.4, 31.11, 31.21 and 31.29 will be excluded when grouping under items A and B.

Hospital cost index or HCI. "Hospital cost index" or "HCI" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare without regard to adjustments in payments imposed by Medicare.

Inpatient hospital service. "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.

Local trade area hospital. "Local trade area hospital" means a MSA hospital with 20 or more Medical Assistance including General Assistance Medical Care, a State-funded program, admissions in the base year that is located in a state other than Minnesota but in a county of the other state in which the county is contiguous to Minnesota.

Metropolitan statistical area hospital or MSA hospital. "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a Minnesota hospital not located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means inpatient hospital costs excluding property costs.

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota excluding MSA hospitals located in a county of the other state in which the county is contiguous to Minnesota.

Property costs. "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.

Rate year. "Rate year" means a calendar year from January 1 through December 31.

Rehabilitation distinct part. "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Relative value. "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within a program at diagnostic category A or B or specialty group C or D. The relative value is calculated from the total allowable operating costs of all admissions. This includes the full, untruncated costs of all exceptionally high cost or long stay admissions. Due to this inclusion of all costs, the relative value is composed of two parts. The basic unit of the relative value adjusts for the cost of an average admission within the given diagnostic category. The additional component of the relative value consists of an adjustment to compensate for the costs of exceptionally high cost admissions occurring within the diagnostic category. This factor, when applied to the base rate and the day outlier rate cause additional payment adjustments to be made to compensate for cost outliers typically found within the diagnostic category. Since all cost is included, the cost outlier threshold is the average cost and is set to pay a cost outlier adjustment for all admissions with a cost that is above the average. The amount of payment adjustment to the operating rate increases as the cost of an admission increases above the average cost.

Transfer. "Transfer" means the movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.

Trim point. "Trim point" means that number of inpatient days beyond which an admission is a day outlier.

3.0 ESTABLISHMENT OF BASE YEARS

A. Except as provided in items B and C, the base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be

supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year for the 1993 rate year of a children's hospital shall be the hospital's most recent fiscal year ending prior to January 1, 1990. A children's hospital is one in which more than 50 percent of the admissions are individuals less than 18 years of age.

C. The base year for the 1993 rate year for a long-term hospital shall be that part of the most recent fiscal year ending prior to September 1, 1989, for which the hospital was designated a long-term hospital by Medicare.

The base year data will be moved forward three years for all hospitals subject to item A, one year for hospitals subject to item B, and two years for hospitals subject to item C beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995 except for 1997 or every one year if notice is provided at least six months prior to the rate year.

4.0 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES

4.01 Determination of relative values. The Department determines the relative values of the diagnostic categories as follows:

A. Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

B. Exclude the claims and charges in subitems (1) to (6):

(1) Medicare crossover claims;

(2) claims paid on a per day transfer rate basis for a period that is less than the average length of stay of the diagnostic category in effect on the admission date;

(3) inpatient hospital services for which Medical Assistance payment was not made;

(4) inpatient hospital claims that must be paid during the rate year on a per day basis without regard to relative values during the period for which rates are set;

(5) inpatient hospital services not covered by the Medical Assistance program on October 1

prior to a rebased rate year;

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges.

C. Separate claims which combine the stay of both mother and newborn into two or more claims according to subitems (1) to (4).

(1) Accommodation service charges for each newborn claim are the sum of nursery and neonatal intensive care unit charges divided by the number of newborns. Accommodation service charges for the mother are all other accommodation service charges.

(2) Ancillary charges for each claim are calculated by multiplying each ancillary charge by each claim's ratio of accommodation service charges in subitem (1) to the total accommodation service charges in subitem (1).

(3) If the newborn's inpatient days continue beyond the discharge of the mother, the claim of the newborn shall be combined with any immediate subsequent claim of the newborn.

(4) If the newborn does not have charges under subitem (1), the ancillary charges of the mother and newborn shall be separated by the percentage of the total ancillary charges that are assigned to all other mothers and newborns.

D. Combine claims into the admission that generated the claim according to readmissions at §12.4.

E. Determine operating costs for each hospital admission using each hospital's base year data according to subitems (1) to (6).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost to charge ratio and add the products of all ancillary services.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of

all teaching program accommodation services.

(4) Determine the cost of malpractice insurance, if that cost is not included in the accommodation and ancillary cost, by multiplying the total hospital costs of malpractice insurance by the ratio of the claim charge to total hospital charges and then multiply that product by 0.915.

(5) Add subitems (1) to (4) to determine the operating cost for each admission.

(6) Multiply the result of subitem (5) by the hospital cost index at §7.0 that corresponds to the hospital's fiscal year end.

F. Assign each admission and operating cost identified in item E, subitem (6), to the appropriate program or specialty group and diagnostic category.

G. Determine the mean cost per admission for all admissions identified in item F within each program and specialty group by dividing the sum of the operating costs by the total number of admissions.

H. Determine the mean cost per admission for each diagnostic category identified in item F within each program and specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

I. Determine the relative value for each diagnostic category by dividing item H by the corresponding result of item G within the program and specialty group and round the quotient to five decimal places.

J. Determine the mean length of stay for each diagnostic category identified in item F by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

K. Determine the day outlier trim point for each diagnostic category and round to whole days.

5.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER

5.01 Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per admission for each hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to §4.01, items A to F, except that the ratios in item E, subitem (2) will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected.

B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments. For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within each program and specialty group, and divide this amount by the number of admissions within each program and specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.02 Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per day outlier for each hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in §5.01, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.